

## **How Doctors Feel: Affective Issues in Patient Safety**

**P Crosskerry, A Abbass, A Wu, *The Lancet* 2008; 372: 1205-06**

Recently, two books have directed attention at the underpinnings of doctor's thinking.<sup>1,2</sup> Thinking (cognitive) failures abound in clinical decision making, especially in diagnostic formulation, and taxonomies of common cognitive errors have been developed.<sup>3</sup> Diagnostic failure has been identified as a major threat to patient safety<sup>4</sup> and, this year, the American Journal of Medicine published a special supplement on the problem<sup>5</sup> coinciding with the first ever symposium on diagnostic error in Phoenix, Arizona.<sup>6</sup> Despite the relative tardiness of this focus on how doctors think, it is a welcome advance in the evolution of patient care and safety. The more difficult next step is to recognize that how doctors feel would also be a complementary and worthy topic for investigation - especially its impact on clinical decision making and patient safety.

Historically, a prevailing view in medicine is that clinical decisions should be objective and freed from contextual affective issues: one could not be objective and rational if emotion entered the reasoning process. Indeed, many of us would consider it a professional virtue to be able to rise above the emotional pull of clinical situations, delivering cool, clear, analytical judgments. However, despite what we might believe, our feelings (affective state) intrude into almost every decision that we make. Our daily interactions with others are influenced by conscious or unconscious social transference phenomena<sup>7</sup> that are affectively polarized in ways that range from the subtle to significant. Similarly, specific clinical situations provoke lesser or greater degrees of affective valence. In fact, our first level of response to anything is an affective one governing the future direction of our relations<sup>8</sup> - we tend to trust our first impressions and stick with them. It seems important, then, to understand the role that affective state plays in clinical decision making.

A consensus is emerging that decision making occurs through one or a combination of two modes: the first (System 1) is intuitive, fast, automatic, frequently involves an affective component, and uses few resources, while the second (System 2) is analytical, slow, deliberate, affect free, and resource intensive.<sup>9</sup> Importantly, most errors of judgment occur in System 1 where affect predominates. System 1 is also where heuristics (mental short-cuts, maxims, rules of thumb) and biases occur. The powerful affect heuristic<sup>10</sup> may significantly influence judgment. For example, certain patients will elicit affective responses from their healthcare providers. Sometimes these are positive, but they may also be negative leading to labeling<sup>11</sup> - patients being referred to as 'complainers', 'difficult', 'high maintenance' or worse. Labeling not only influences clinician's thinking but also that of other healthcare providers. In some cases e.g., borderline personality disorder, the visceral reactions elicited by the patient in their provider may be the basis for making the diagnosis.<sup>12</sup> Affective valence towards patients, positive or negative, compromises decision making. The best evidence may be degraded when it is unconsciously passed through an affective filter.

The concept of affective influence on decision making will be unfamiliar to many clinicians. Efforts should be made to raise awareness of how affect influences clinical performance, as well as describing its multiple forms. The table provides a preliminary taxonomy that groups affective dispositions to respond (ADRs) towards patients into three main categories. The first are affective states in the caregiver that may be induced

by the immediate environment or work conditions e.g. irritability induced by high level of ambient noise, or negative affective states associated with sleep deprivation. The second are affective biases that are context or patient specific. One of the most powerful is *counter transference* in which the caregiver feels positively or negatively towards the patient due to experience with previous exemplars. A second is *fundamental attribution error*, where patients may be judged on the basis of dispositional qualities rather than circumstantial ones e.g. blaming patients for their obesity rather than underlying socio-economic factors that might have led to their condition; there are a variety of others. The third are endogenous affective states within the clinician: some that depend upon a variety of temporal factors, others on mood disorders, and emotional avoidance leading to mistreatment or neglect of patients.

In conclusion, there is increasing evidence, mostly from the field of psychology, that affective factors may influence physicians in the diagnostic process, medical decision making, and interactions with patients. We believe there is a growing imperative for medical educators to understand and incorporate this knowledge into clinical training.

**Table. Taxonomy of Affective Dispositions to Respond (ADRs) with examples**

A. *Transitory affective states*

- Environmental
- Sleep deprivation, sleep debt
- Irritability
- Stress
- Fatigue

B. *Clinical situation-induced*

- Specific affective biases
- e.g. Fundamental attribution error
- Counter transference

C. *Endogenous disorders*

- Circadian, infradian, seasonal mood variation
- Mood disorders
- Anxiety disorders
- Emotional avoidance

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